



OIT Newsletter

INDIAN HEALTH SERVICE + OFFICE OF INFORMATION TECHNOLOGY



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About This Issue

This issue features two articles on Telehealth at IHS, one providing some general history about telemedicine's beginnings and the other describing the value of telenutrition programs in Indian Country.

As always, the issue includes updates on two major initiatives—the ICD-10 Transition and Meaningful Use at IHS—as well as a description of the support provided for these initiatives by NIHB REC.

Last but not least, learn about a new web application for food handlers, CPIC Stage Gate Reviews, and upcoming changes to account provisioning at IHS.

Happy reading!





Telehealth

About Telemedicine and IHS

by David R. Boyd MDCM, FACS, with the assistance of Jacqueline M. Dowell MD and Mark Carroll MD

Editor's Note: This is the first in a series of articles adapted from the *Tele-Trauma and Tele-Acute Care Medicine* manual created by the IHS Trauma Care and Injury Prevention Program (TCIPP).

The IHS is the principal federal healthcare provider and health advocate for American Indian people, providing a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives (AI/AN) who belong to 564 federally recognized Tribes through a network of 44 hospitals and more than 600 other facilities operated by the IHS, Tribes, and Alaska Native corporations.¹ Our foundation is to promote healthy AI/AN people, communities, and cultures, and to honor the inherent sovereign rights of Tribes.² In Indian health, Health Information Technology (HIT) supports and facilitates an array of activities focused on effective healthcare delivery and efficient resource management. Telemedicine is an increasingly critical part of patient-centered care - within a community orientation and population health perspective. These rapidly evolving tools and capabilities enhance timely consultation, diagnosis, and treatment, supporting best practice approaches to care. They enable new models of quality service delivery, models that emphasize relationships and communication while facilitating improved health care quality, cost-effectiveness, and value. In the IHS, delivering the right care in the right place at the right time is a top priority. Used correctly, telemedicine tools promote and enhance the patient-care team and care team-specialist relationships.



What Is Telemedicine?

Telemedicine is a means of medical care that helps eliminate access to care barriers in an effort to improve quality in underserved locations. The origin of the word *tele*, from the Greek, means far off, or at a distance. Telemedicine first gained popularity in the early 1900s when “radios were used to link physicians standing watch at shore stations to assist ships at sea that had medical emergencies.”³

The technology has since advanced beyond radios to telephones, satellites, and internet connections and is now broken into three categories:

- ◆ Store-and-forward telemedicine is a type of service in which patient images and data are securely and asynchronously available for remote consultation.

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¹ Carroll M, Cullen T, Ferguson S, Hogge N, Horton M, Kokesh J. Innovation in Indian healthcare: using health information technology to achieve health equity for American Indian and Alaska Native populations. *Perspect Health Inf Manag*. 2011 Jan 1;8:1d.

² Hays, Howard. “Department of Health and Human Services Statement before the United States Senate Committee on Indian Affairs on ‘Internet Infrastructure in Native Communities: Equal Access to E-Commerce, Jobs and the Global Marketplace.’” 6 Oct 2011.

³ <http://users.forthnet.gr/ath/giovas/telemed>



About Telemedicine and IHS *continued*

- ◆ Remote monitoring and care coordination refers to care models that utilize home and community-based tools for improved clinical care.
- ◆ Real-time telemedicine involves interactive services via videoconferencing.

The focus of these articles will be real-time care, using both novel videoconferencing methods and rapid response store-and-forward tools, so that timely and accurate diagnoses can be provided for trauma care in remote locations at Indian Health facilities.

Telemedicine in Indian Country

The use of telemedicine is not new to Indian country. In the early 1970s, the IHS pioneered mobile telemedicine service through the "Space Technology Applied to Rural Papago Advanced Health Care" (STARPAHC) project. STARPAHC represented a novel use of leading edge technology and communications to provide mobile outreach to Tribal communities in southern Arizona. Over 25 years later, Indian health again demonstrated leadership in telemedicine service delivery innovation, through the collaborative development of the Alaska Federal Health Care Access Network (AFHCAN). AFHCAN has demonstrated significant improvements in access, quality, and value. For example, the use of tele-consultation via the AFHCAN store-and-forward solution has significantly reduced waiting times for Ear, Nose and Throat (ENT) specialist evaluations, decreasing the percentage of patients who wait four or more months for an ENT evaluation in one Alaska village community from 48%, before telemedicine, to less than 3% after telemedicine began.⁴ The expanded use of telemedicine in Alaska has increased access to health care while significantly decreasing patient related travel costs. Such savings create opportunities for additional care.



STARPAHC project van

Telemedicine tools such as videoconferencing and on-line training can expand access to education and advanced degrees. Such training decreases unnecessary travel, saving money for communities and community members. It increases the ability of local hospitals and businesses to recruit and retain staff that otherwise may be required to leave communities to pursue their education and training. It aids Indian health in leadership succession planning. It even allows Tribal health programs to develop service models in which the expertise can be provided by those programs to other regions and geographies, rather than the often experienced situation in which Native communities are dependent on expertise from specialty groups in urban environments.



⁴ Hofstetter, P. J., J. Kokesh, A. S. Ferguson, and L. J. Hood. "The Impact of Telehealth on Wait Time for ENT Specialty Care." *Telemedicine and e-Health* 16, no. 5 (2010): 551–56



Telehealth

Expanding Medical Nutrition Therapy (MNT) Access

by Diane Phillips, IHS Telenutrition Program Director, and Tammy Brown, Nutrition Consultant

Five of the six leading causes of death among American Indian and Alaska Native (AI/AN) people are nutrition-related. Unfortunately, most AI/AN communities do not have adequate access to nutrition services.⁵

For the 2009 IHS Diabetes Care and Outcomes Audit, only 50% of AI/AN people with diabetes received diet education, and only 26% were seen by a registered dietitian for medical nutrition therapy (MNT).⁶

Telehealth provides a new service model for health care facilities to increase access to MNT and diabetes self-management education (DSME). This integration of technology with MNT and DSME empowers patient self-care management and facilitates continuous, uninterrupted nutrition and diabetes education services in rural health professional shortage areas, with positive results and patient and provider satisfaction.⁷ When asked if the telehealth visit with the nutritionist was about what the patient had expected and led to a better understanding of the treatment, 79% said yes.⁸ Individual and group telenutrition services as well as diabetes self-care management education (DSME) are reimbursable services through Medicare for patients with diabetes, end-stage kidney disease, or kidney transplant.⁹

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"There is a serious and alarming shortage of registered dietitians in the Indian health system. Telenutrition service offers more opportunities for American Indian and Alaska Native patients to individualized and group medical nutrition therapy.

Telenutrition services are covered by Medicare Part B for individual and group for individuals with diabetes and non-dialysis kidney disease. To learn more about MNT reimbursement, order 'Step-by-Step Guide to Medical Nutrition Therapy Reimbursement, 2nd Edition, 2011' through the IHS Division of Diabetes Online Catalog available at <http://www.ihs.gov/MedicalPrograms/Diabetes/RESOURCES/Catalog/rde/index.cfm>."

*~ CAPT Tammy Brown,
RD, MPH, CDE, BC-ADM*

⁵ Sandoval W, Brown T, Broussard BA. Medical nutrition therapy works, saves money, and makes money, Part 1: increasing access to nutrition services. *IHS Provider*. 2007;32:65-69.

⁶ U.S. Department of Health and Human Services. Indian Health Service Division of Diabetes Treatment and Prevention. 2009 IHS Diabetes Care and Outcomes Audit, Albuquerque, NM.

⁷ - Dalton JE. Web-based care for adults with type 2 diabetes. *Canadian J Diet Prac and Research*. 2008;69(4):185-191.

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- Davis RM, Hitch AD, Salaam MM, Herman WH, Zimmer-Galler IE, Mayer-Davis EJ. Telehealth improves diabetes self-management in an underserved community. *Diabetes Care*. 2010; 33(8):1712-1717.

- West SP, Laguna C, Trief PM, Izquierdo R, and Weinstock RS. Goal setting using telemedicine in rural underserved older adults with diabetes: experiences from the informatics for diabetes education and telemedicine project. *Telemed J E Health*. 2010;16(4):405-416.

⁸ Johnson A, Gorman M, Lewis C, Baker F, Coulehan N, Rader J. Interactive videoconferencing improves nutrition intervention in a rural population. *J Am Diet Assoc*. 2001;101(2):173-174.

⁹ Centers for Medicare and Medicaid Services. Expansion of Medicare telehealth services for calendar year 2011. *Medicare Learning Network Matters*. Jan. 03, 2011, Number MM7049.



Expanding Medical Nutrition Therapy (MNT) Access *continued*

Telehealth expands the definition of telemedicine and is more consistent with the scope of practice of the registered dietitian.¹⁰ In addition to clinical care, it encompasses disease prevention and health promotion. The American Dietetic Association specifically defines *telepractice* as a subset of telehealth, which "involves the interactive use, by any health care providers (including registered dietitians), of electronic information and telecommunications technologies to engage in the diagnosis, evaluation, and treatment of patients or clients at a remote location through means such as teleconferencing."¹¹

The IHS Telenutrition Program began providing nationwide individual and group medical nutrition therapy (MNT) and other nutrition services through video-conferencing to IHS and tribal facilities in November of 2006. LCDR Diane Phillips (RD, LD, CDE) at the Native American Cardiology Program in Flagstaff AZ is one of the first registered dietitians in the IHS to provide MNT telepractice, delivering real-time medical nutrition therapy (MNT) services at a distance through the use of video-conferencing equipment. Phillips has used telehealth to deliver MNT services to the Fort Peck Service Unit (Wolf Point MT and Poplar MT), Crow Service Unit (Crow MT), the Elko Service Unit (Elko NV), the Hopi Health Care Center (Paolacca AZ), and the Supai clinic in a remote village on the floor of the Grand Canyon (Havasupai AZ). The telenutrition program has provided access to nutrition services to over 1500 patients who otherwise would not have received these services. In addition, over 150 hours of nutrition training have been provided to community-based diabetes outreach workers and fitness instructors.



LCDR Phillips providing telenutrition services from Flagstaff, AZ, to a patient at the Hopi Health Care Center, Paolacca AZ

"The patients really like the telenutrition services. I feel that the patients are more honest with Diane and feel comfortable that they can share more personal information."

*~ Sherri Don't Mix
Diabetes Outreach Worker
Crow Tribal Diabetes Program
Crow Agency, MT*

"There is a critical registered dietitian shortage in Indian health. Telenutrition is a great way to maintain as well as augment medical nutrition therapy services in our facilities."

We are just touching the surface of possibilities with telenutrition in Indian health. Currently, it is offered on an outpatient basis. I envision that this could be expanded to inpatient where you have aides take monitors into the patients' rooms and have RD do an assessment remotely using telehealth."

*~ Charlene Johnson
MPH, RD, CDE
Billings Associate Area Director
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¹⁰ Bender T, Folse SB, Lopez R. Telehealth: what it is and the potential for reimbursement. *Weight Management Matters*. 2009;7(2):1-6.

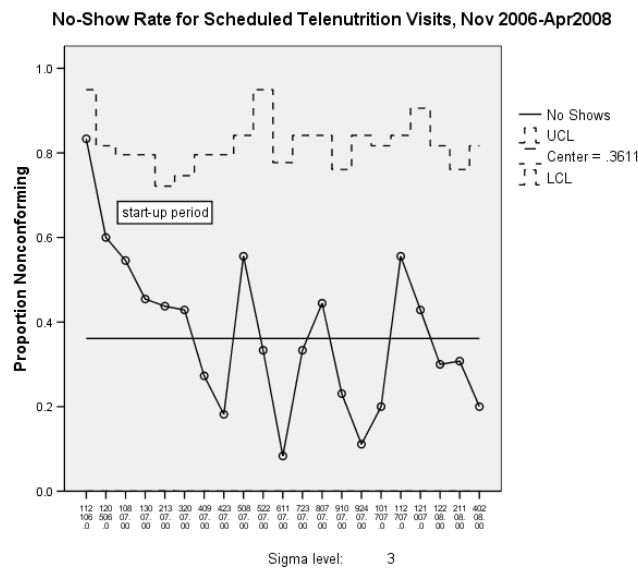
¹¹ Busey C, Michael P. Telehealth-opportunities and pitfalls. *J Am Diet Assoc*. 2008;108(8):1296-1301.



Expanding Medical Nutrition Therapy (MNT) Access *continued*

The success of the IHS National Telenutrition Program has resulted in more IHS and Tribal health sites offering additional services through telehealth to expand nutrition training and medical nutrition therapy provided by a registered dietitian. It is seen as one solution by administrators and clinicians to expand nutrition services and increase access and quality of care. Other IHS facilities that have explored or implemented telenutrition services include Sells Service Unit, Phoenix Indian Medical Center, and Whiteriver Service Unit. Sites interested in telenutrition service purchase a portion of a registered dietitian FTE to meet their facilities medical nutrition therapy needs.

Failure-to-keep-appointment rates for IHS Telenutrition Program services have been lower than failure-to-keep-appointment rates for conventional in-person nutrition counseling as shown in the graph below.



Telenutrition meets the IHS Director’s Initiative #1: Strengthening Partnership with Tribes and #3: Improving Quality and Access. Telenutrition provides a source of revenue and has been shown in research and IHS/Tribal health facilities to be well accepted by patients and equally effective as in-person encounters. IHS Medical Nutrition Action Team effectively uses telehealth to provide continuing education webinars to health care professionals; expanding training to reach isolated and rural providers. In summary, telehealth offers an effective and efficient means to extend the reach of registered dietitians in Indian health to provide medical nutrition therapy and diabetes education to patients and provide continuing education to providers.

Acknowledgements

The authors are grateful to Charlene Johnson, MPH, RD, CDE, Billings Associate Area Director - Office of Health Care Programs, Billings, MT and Sherri Don’t Mix, Diabetes Outreach Worker, Crow Tribal Diabetes Program for their contributions to this article.





ICD-10 Transition

ICD-10 Proposed Delay Keeps IHS on Track

by Janice Chase and Kathleen Keats, ICD-10 National Team

Many people assume that since HHS has proposed to delay the ICD-10 compliance date to October 1, 2014, we can relax for a year. This is not a good strategy!

If the proposed compliance date becomes final, the delay to 2014 allows IHS to solidify requirements, gives more time for integrated testing, and provides needed time for RPMS development, given the competing constraints of Meaningful Use Stage 2. The original compliance date of October 1, 2013 is approaching rapidly and the postponement will further allow OIT to methodically incorporate ICD-10 and Meaningful Use Stage 2 development concurrently. The shift in compliance date will enable enhanced preparation for this important transition.

Top 10 Steps for ICD-10

Take advantage of the increased time for compliance by preparing thoroughly for the transition in your Area and facility:

1. Provide any functional or technical requirements needed for the ICD-10 transition.

Although the requirements freeze date has passed (June 1, 2012), any additional requirements can be captured for future releases of RPMS modules.

2. Prepare for conflicting priorities.

Meaningful Use Stage 2 is on the horizon and will be competing for software development resources. We are continuing on our original development schedule to maintain momentum and to use available funds.

3. Create a robust integrated testing program.

The increased time allows more subject matter experts to participate in integrated testing and allow payers time to test with IHS.

4. Build foundational skills.

ICD-10 requires a great deal of knowledge of anatomy, physiology, medical terminology, pharmacology and biosciences. Use the time to build the foundational knowledge of all who will apply and use ICD-10 codes.

5. Improve clinical documentation.

The granularity of ICD-10 necessitates precise and accurate clinical documentation that allows coders to extract information for coding. This time can be used to improve clinical documentation to incorporate laterality, site information and reduce unspecified codes, at the very least.

6. Update RPMS to the latest patches.

Be sure to implement code set versioning, HIPAA 5010, and other patches.

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ICD-10 Proposed Delay Keeps IHS on Track continued

7. Look for cost-effective training solutions.

Join with other Areas to provide low-cost training solutions or build in-house programs. Take advantage of any national training or collaborative training with other agencies or Tribal programs.

8. Recruit new coders with training in ICD-10.

Retain experienced coders and prepare them for the transition.

9. Clean up any backlogs of visits in the coding queue and claims.

Use the time to correct any rejected claims before the new compliance date.

10. Generate a budget for the transition.

Keep in mind training costs, loss of productivity during the learning curve, the resources needed for ICD-10 and Meaningful Use, impacts to patient scheduling, and impacts to the revenue stream.

Hopefully, the ten reasons given will encourage you to continue with your ICD-10 planning and not wait a year to begin. The IHS ICD-10 project team is not waiting and is continuing outreach, training, and development activities. Don't Delay; October 1, 2014 is right around the corner.





Meaningful Use

Transitioning to Meaningful Use Stage 1, Year 2

by JoAnne Hawkins, Sr. Healthcare Policy Analyst, MU National Team

The year 2011 was the beginning of Stage 1 Meaningful Use. Many Eligible Hospitals and Eligible Professionals throughout Indian Health Systems participated in either the Medicare or Medicaid program for 2011. Across Indian Country approximately \$17,634,404 in CMS EHR Incentive payments have been received. We would like to congratulate all Eligible Hospitals and Eligible Professionals that have taken all necessary steps to participate in the EHR Incentive program.

Stage 1 is not over, only the first year. Stage 1 continues through 2012. So, what does that mean?

Eligible Hospitals

Eligible Hospitals that participated only in the Medicaid program for FY2011 by attesting to Adopting/Implementing/Upgrading (A/I/U) to a Certified Electronic Health Record will need to demonstrate Meaningful Use of a Certified Electronic Health Record for a 90-day consecutive period for FY2012. Continuing to meet the patient volume thresholds is an annual eligibility requirement.

Eligible Hospitals that participated in the Medicare program for FY2011 will have already demonstrated Meaningful Use of a Certified Electronic Health Record for a 90-day period. For FY2012, the Eligible Hospital will need to demonstrate Meaningful Use for 365 days. The reporting period for demonstrating Meaningful Use begins on the first day of the fiscal year; for FY2012, that would have been October 1, 2011.

Remember all Eligible Hospitals within IHS are considered dual-eligible for the CMS EHR Incentive program and can participate in Medicare and Medicaid simultaneously using the same reporting period.

Eligible Professionals

Eligible Professionals who participated in the Medicaid program for CY2011 by attesting to (A/I/U) will need to demonstrate Meaningful use of a Certified Electronic Health Record for a consecutive 90-day period for CY2012.

Eligible Professionals who participated in the Medicare program for CY2011 already demonstrated Meaningful Use for a 90-day period. For CY2012, they will need to demonstrate Meaningful Use for 365 days. The reporting period for demonstrating Meaningful Use begins on the first day of the calendar year; for CY 2012, that would have been January 1, 2012.

Still Want Maximum Incentives?

If you have not participated in either program, it is not too late to start. In order to receive the maximum incentives under the Medicare program you must participate in 2012.

If you have questions on what it means to achieve Meaningful Use, please reach out to your Area Meaningful Use Coordinator or the Regional Extension Center.

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Transitioning to Meaningful Use Stage 1, Year 2 continued

Stage 2

The Notice of Proposed Rule Making (NPRM) for public comment and review for Stage 2 of Meaningful Use and 2014 EHR Certification was released in February by CMS and ONC. Extensive, ongoing analysis is underway by the Meaningful Use National Team to prepare for Stage 2. RPMS EHR must be recertified in order to meet the Stage 2 Meaningful Use requirements. There will be increased thresholds for some performance measures, and there will be additional measures added. The final rule for both the CMS and ONC will be published later this summer. At that time, plans for upgrading RPMS EHR and its associated reports will be finalized.

MU Website and ListServ

Information about Stage 1, Stage 2, and other MU topics will continue to be distributed using the MU Website and ListServ. To sign up, go to <http://www.ihs.gov/meaningfuluse/> and click on the ListServ link.





NIHB

NIHB REC Support for Indian Health

by Tom Kauley, AI/AN National REC Consultant for the National Indian Health Board (NIHB)

The National Indian Health Board (NIHB) Regional Extension Center (REC) has signed up and received funds to provide REC health IT services to 2,550 Primary Care Providers working in 437 Indian Health Service (IHS), Tribal, and Urban Indian (I/T/U) health facilities across the U.S. The NIHB REC is the only HITECH REC funded by the Office of the National Coordinator for Health IT (ONC) with a nationwide service area. NIHB REC teams work in close partnership with the IHS EHR Deployment Team, IHS Meaningful Use (MU) Team, and all IHS Area Office health IT teams to support continued deployment and meaningful use of the RPMS EHR in over 325 I/T/U sites. NIHB REC teams also support the deployment of commercial EHRs at Tribal and Urban health facilities.

Sub Recipient Organizations

The NIHB REC's Sub Recipient teams are the driving force for the successful delivery of REC services and provide direct, boots-on-the-ground EHR and MU services to providers and staff in I/T/U facilities. Sub Recipient organizations include:

- ◆ Alaska Native Tribal Health Consortium (ANTHC)
- ◆ California Rural Indian Health Board, Inc. (CRIHB)
- ◆ Northwest Portland Area Indian Health Board (NPAIHB)
- ◆ United South and Eastern Tribes, Inc. (USET)

Sub Recipient teams are using NIHB REC funds to acquire the services of Pharmacy/Nurse/Lab Clinical Consultants, Health Information Management Consultants, and IT Support Specialists to work with all I/T/U facilities and support their goal of achieving the meaningful use of EHRs.

EHR Support to I/T/U Facilities

Although EHR deployment is the first major step toward improving health care for the Nation's American Indian and Alaska Native (AI/AN) population, optimal and meaningful use of the EHR is the key to producing long-term, improved health care outcomes. NIHB REC teams are providing a number of innovative REC services to train and optimize the use of EHRs by the providers they serve. Some of unique NIHB REC services provided to I/T/U facilities include:

- ◆ Health care transformation consulting services provided by professional consultant team.
- ◆ Clinical Applications Coordinator Mentorship Program to provide local health IT technical support and training.
- ◆ RPMS IT Support Services for Tribal sites to assist facilities that have limited availability of IT staff.
- ◆ Clinic Workflow Workgroup to produce training materials for workflow redesign to use in training providers and staff in I/T/U facilities.

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NIHB REC Support for Indian Health continued

Workforce Training

The NIHB REC is also currently working with the American Higher Education Consortium to implement a Pilot Native Health IT Workforce Training Program at Tribal Colleges and Universities. The goal of this workforce training program is to develop a local health IT workforce to serve tribal communities now and in the future.

National Tribal Best Practices Conference

NIHB REC Sub Recipients, USET and ANTHC, will co-host the "National Tribal Best Practices Conference" during July 22-26, 2012 in Salt Lake City, UT. The 2012 Tribal Best Practices Conference is a national gathering of health care providers and professionals, community health advocates, health IT specialists, and leadership in the IHS, Tribal and Urban Indian health care systems. This conference will include workshops for health IT staff, medical providers and tribal health leaders. More information for this conference may be accessed at the following web link <http://www.ntbpconference.com/>.



Web Services

New Food Handler's Training Application

by Denean Standing-Ojo, Assistant Web Services Manager

Every year, the Albuquerque Area Division of Environmental Health Services (DEHS) trains about 3,500 people to prepare safe food for their communities at restaurants, casinos, schools, and assisted living homes. These facilities often have a high staff turnover rate and request more training, making the Food Handler Training one of the most requested services from the Albuquerque Area DEHS. Each year, they conduct an average of 100 classroom training sessions across New Mexico, Southern Colorado, and parts of Texas. The classroom training requires printed materials, employee instruction, and travel—all of this coming to a total estimated cost of \$195 per class, or \$19,500 per year.

In the spirit of maximizing their resources, the Albuquerque Area DEHS team brought their idea for an online class to Web Services, and the Online Food Handler's Training web application was built.

The application allows food handlers to:

- ◆ Register for training.
- ◆ View the food sanitation training course.
- ◆ Take the quiz.
- ◆ Get their IHS Food Handlers certificate.

It allows the Albuquerque Area DEHS staff to:

- ◆ View registration information
- ◆ Run data reports.
- ◆ Gather and review feedback from trainees.
- ◆ Measure the effectiveness of their training program.
- ◆ Improve services to tribal customers.

The application has made it possible for the Albuquerque Area DEHS to consolidate the number of in-person training sessions. It is projected to be utilized by at least 10% of their trainees, resulting in an estimated cost savings of \$1,950 this year.

The Online Food Handlers Training has the high potential to be beneficial to other Areas who are facing similar issues and are looking to make the most of their resources. It can be tailored to be Area-specific, allowing the Indian Health Service to meet the unique needs of the tribal communities we serve throughout the country.

You can find the training at <http://www.ihs.gov/foodhandler/>. Questions and comments about the web application can be emailed to IHSWebAdmin@ihs.gov.

NOTE: A special thanks goes to Katie Noonan-Hubbard from the Albuquerque Area DEHS for helping with this article.





CPIC Corner

Project Life Cycle & IT Governance

by Carl Gervais, IHS OIT CPIC Manager

In today's high technology environment, IT Governance can mean the difference between success and failure. Many organizations, including HHS, identify information technology as an area in their operation that needs to be protected through IT Governance. Over the last several years, there have been many driving forces causing organization dependency on information systems. In response, the extensiveness, scope and importance of information resources warrant a federated approach that will balance the responsibilities and accountability on each project's life cycle.

IT Governance enables IHS to ensure that projects and investments align to strategic priorities, deliver promised results, and report costs, progress, and problems in a timely manner. Each principle is given earnest consideration in the interest that improved adjustments may be made. The role of the IT Governance at IHS is to effectively communicate these priorities, make decisions that will reduce program risk, and improve overall performance.

Guiding Principles of IT Governance

- ◆ Support the effective oversight and governance of information resource spending
- ◆ Provide proficient guidance for the management and use of information and information technology services
- ◆ Ensure active integration of IT between program, and service provision throughout the organization
- ◆ Integrate an enterprise IT Governance process at all levels of the agency
- ◆ Promote consistent charters including scope, mission, function throughout the enterprise governance processes

In support of these guiding principles, the Stage Gate Review evaluates the process by which a project is authorized to progress from one life cycle phase to the next. The Stage Gate Review emphasizes a comprehensive plan for the next life cycle phase, the accomplishment of the phase objectives, the risk associated with moving to the next step, and the availability of resources to execute the next step.

Stage Gate Reviews at IHS

Of the ten Stage Gate Reviews in the Enterprise Performance Lifecycle (EPLC) process, five are required to have IT Governance review and/or approval. The Initiation and Concept Phase Stage Gate Reviews have been implemented at IHS, and implementation of the Planning Phase Stage Gate Review is currently underway. This stage gate involves the scoring of project documents by a peer review group, and the results of that review then go before the Technical Review Board (TRB) for a go/no-go vote.

The pilot projects currently going through the Planning Stage Gate Review are:

- ◆ ICD-10
- ◆ AD/Exchange Provisioning
- ◆ Web Content Management System





Technology Update

Upcoming Changes to Account Provisioning at IHS

by Stephen Freeman, ETS Team Lead

The IHS/OIT Enterprise Technology Service (ETS) and Central E-mail Service (CES) teams recently kicked off the Active Directory (AD)/Exchange Account Provisioning project at OIT. As part of the project, OIT will be implementing a tool enterprise-wide called **NetIQ Directory and Resource Administrator (DRA)**. NetIQ DRA's advanced delegation and robust, policy-based administration capabilities improve the security and efficiency of Active Directory administration.

In IHS, the tool will work as a front-end Web interface for provisioning resources in Active Directory and Exchange, ensuring that provisioning is completed in a much more efficient and standard method than allowed for today by the Microsoft native tools and HEAT ticket requests for Exchange resources. Some of the major efficiencies range from enforcement of standard and consistent Active Directory Object Attributes during account creation across the IHS enterprise, to returning the delegation of mailbox creation back to the Area IT staff. In addition to making the account/mailbox provisioning process run more efficiently, the NetIQ DRA tool will allow IHS to meet the HHS directive to establish directory and attribute standards and maintain continuity for the HHS Global Directory.

Along with implementation of the NetIQ tool, OIT is currently establishing Active Directory object attribute naming standards to include workstation names, server names, and security group names. The naming standards will be enforced in the NetIQ DRA web interface when provisioning those objects in Active Directory and Exchange.

Once the configuration and testing of the NetIQ DRA tool is complete, it will be rolled out across IHS on an Area-by-Area and Site-by-Site basis, in order to minimize impact to the production environment and ensure that every IHS IT Administrator receives proper attention and training during the migration.

These are exciting times for the IHS Active Directory and Exchange environment at IHS. Later this year, look for the NetIQ DRA to be coming to an administrator near you!





News to Use

RPMS & EHR Training Update

By Kimberlee Crespin-Richards, OIT Training Coordinator

Completed Training

During the past quarter (January - March 2012), the Office of Information Technology (OIT) sponsored and completed the following training for the Resource and Patient Management System (RPMS) and the Electronic Health Record (EHR):

AREA	SESSIONS	EST. PARTICIPANTS
Aberdeen	7	71
Albuquerque	10	127
Alaska	20	96
Bemidji	6	64
Billings	3	33
California	8	119
Nashville	6	48
Navajo	4	51
Oklahoma City	8	92
Phoenix	8	94
Portland	6	52
Tucson	4	35
Web-Based	47	970
TOTALS	137	1852

Scheduled Training and Registration

To register for OIT sponsored RPMS and EHR training, please visit the following link:

<http://www.ihs.gov/RPMS/index.cfm?module=Training&option=index&sortChoice=Title&newquery=1>



Contributors

- ◆ **Dr. David Boyd** is the National Trauma Systems Coordinator in the Office of Emergency Services (ES), Indian Health Service (IHS), in Rockville MD. He is the COTR of the IHS-UNM Tele-Radiology and Co-Innovator of the IHS-UAZ "Smart Phone" Projects. He is the IHS representative to the Federal Inter Agency Committee for Emergency Medical Services (FICEMS) and Council on Emergency Medical Care (CEMC) other coordinating entities.
- ◆ **Tammy Brown**, MPH, RD, BC-ADM, CDE, is a Nutrition Consultant with the IHS Division of Diabetes Treatment and Prevention in Albuquerque NM.
- ◆ **Janice Chase**, RHIT, is the Federal Lead for HIM applications, ICD-10, and CMS Integrated Data Repository, responsible for the management and oversight of planning and implementation of these programs. She is based in Tucson AZ.
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About the OIT Newsletter

The IHS OIT Newsletter is sponsored by Acting IHS CIO Dr. Howard Hays. It is published several times throughout the year, with the objective of communicating IHS Office of Information Technology activities to all IHS personnel.

All articles and suggestions for articles are welcome. If you would like to submit an article or have any questions regarding this publication, please contact the editor, Heli L. Roosild (CNI), at: Heli.Roosild@ihs.gov. (All articles are subject to change without notice.)